

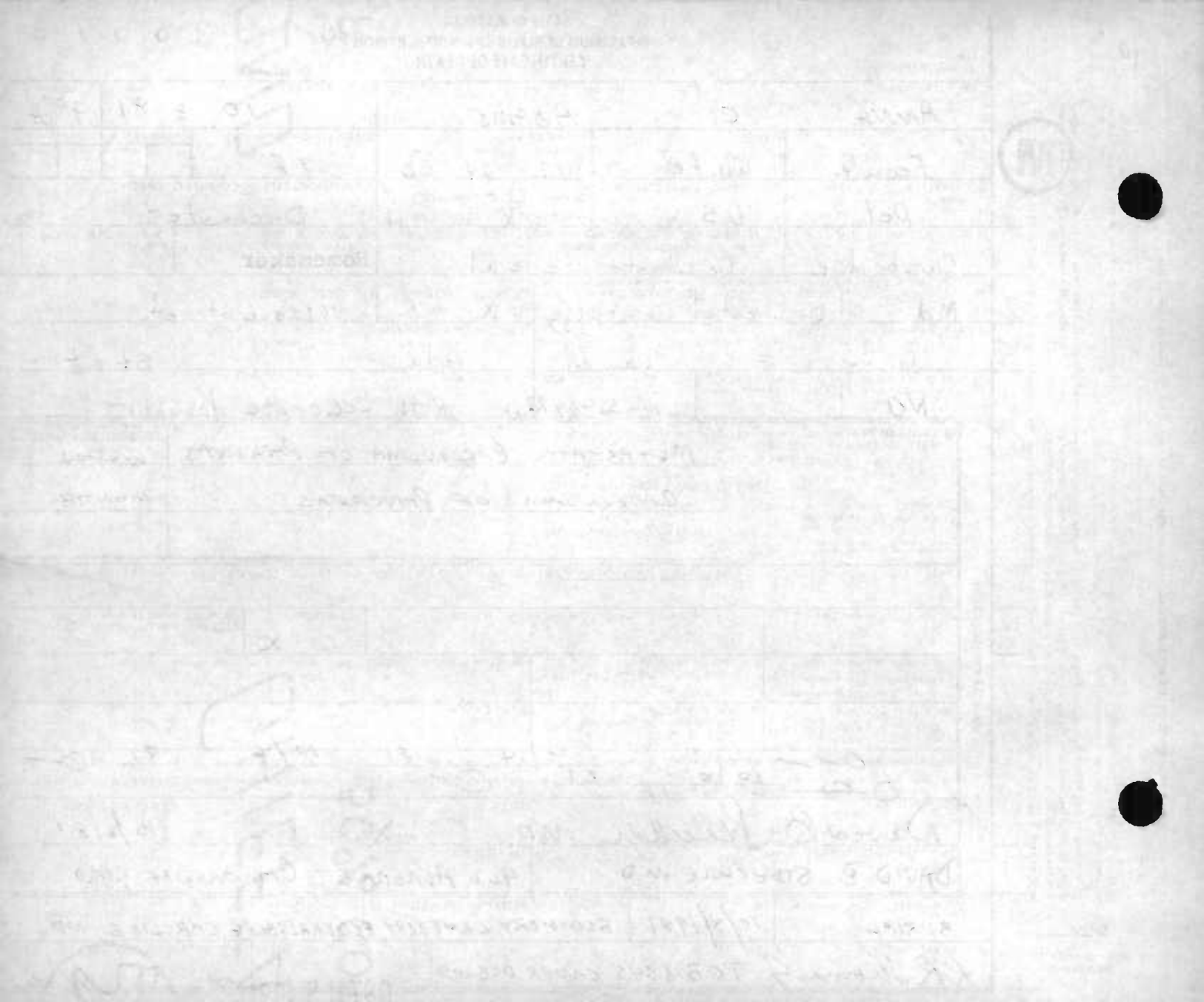
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 2 6 0 7 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA C. ADAMS						2a. DATE OF DEATH MONTH DAY YEAR 10 6 81				2b. HOUR 9 <sup>00</sup> A.M.	
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 12 24 03		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md						13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James E Cannon						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Strait					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2 14-32-6972D		17. INFORMANT Ruth LeCompte daughter				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF PANCREAS 1579 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) the hospital attended the deceased from 9/14, 19 81, to 10/6, 19 81, that (b) I saw the deceased alive on 10/6, 19 81, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If not, do not view the body after death.)											
22b. SIGNATURE David B. Stockle M.D.						DEGREE M.D.		22c. DATE SIGNED 10/6/81		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOCKLE M.D.						22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/8/1981		23c. NAME OF CEMETERY OR CREMATORY BLOOMERY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FEDERALSBURG CAROLINE MD.			
24. FUNERAL DIRECTOR K R Thomas Jr. PO BOX 348 CAMBRIDGE MD						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Apt 13 1001 21 D. G. H.			



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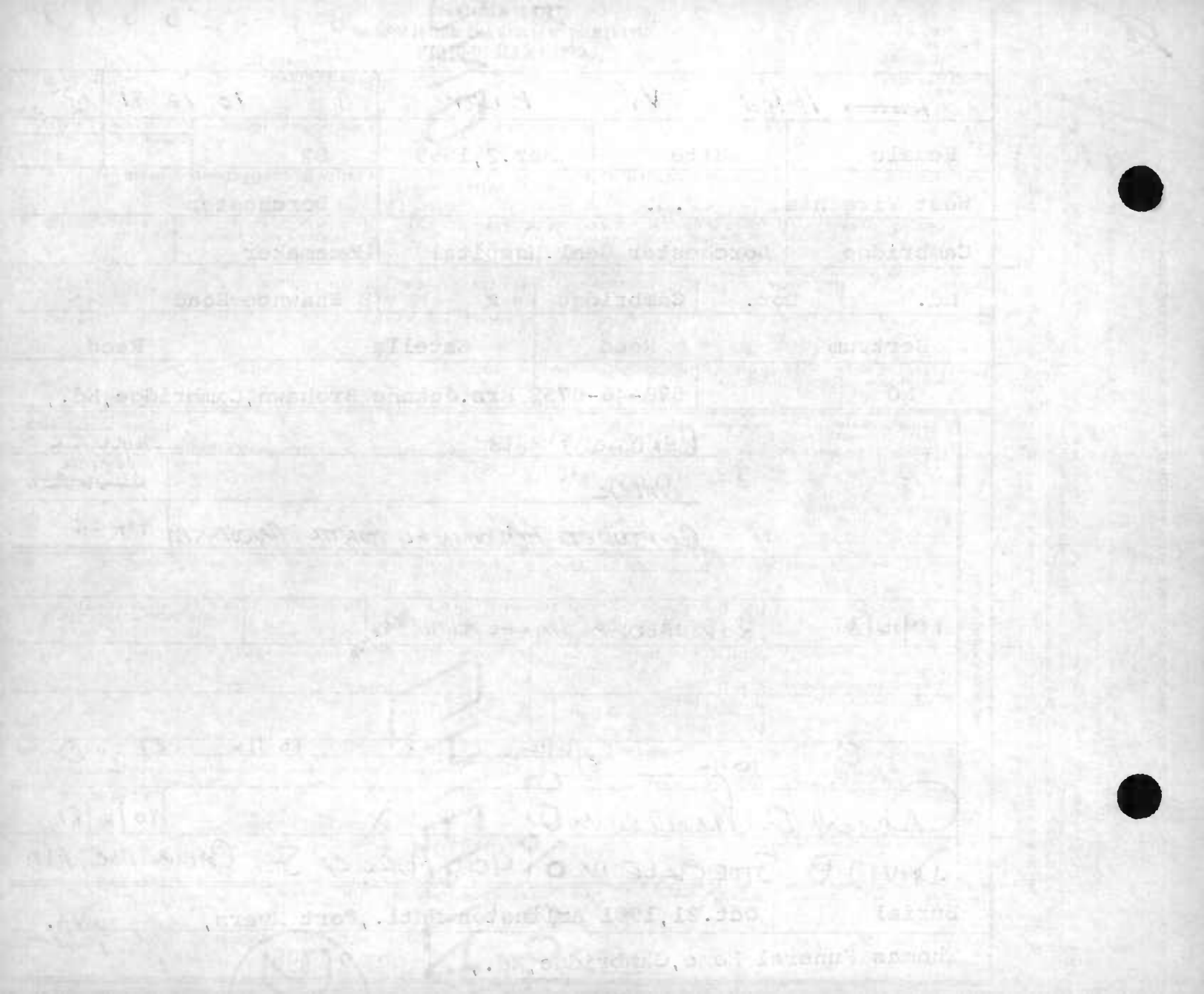
DHMH-16 50M/7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 6 7 9

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		10 16 81		1 35 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR Mar. 2, 1899		82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia		U.S.				Dorchester MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester Genl. Hospital		Homemaker			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
13a. STATE COUNTY		13c. CITY OR TOWN		8 Shawnee Road			
Md. Dor.		Cambridge					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO		4578-46-8752	
Bertrum		Reed				17. INFORMANT ADDRESS	
						Mrs. Joanne Brohawn, Cambridge, Md.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4413		DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK		DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED ABDOMINAL AORTIC ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES HOURS MINUTES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
10/16/81		RUPTURED ABDOMINAL AORTIC ANEURYSM		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED? ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/16 19 81, to 10/16 19 81, that (I) (we) lost saw the deceased alive on 10/16 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE David B. Stoeckle MD		22c. DATE SIGNED 10/16/81			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE REC'D. BY REGISTRAR		22e. REGISTRAR'S SIGNATURE	
DAVID B. STOECKLE MD		400 AURORA ST. CAMBRIDGE, MD		OCT 21 1981		James J. Smith	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 21, 1981		Arlington Natl.		Fort Myers, VA	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Thomas Funeral Home, Cambridge, Md.		OCT 21 1981		James J. Smith			

BP



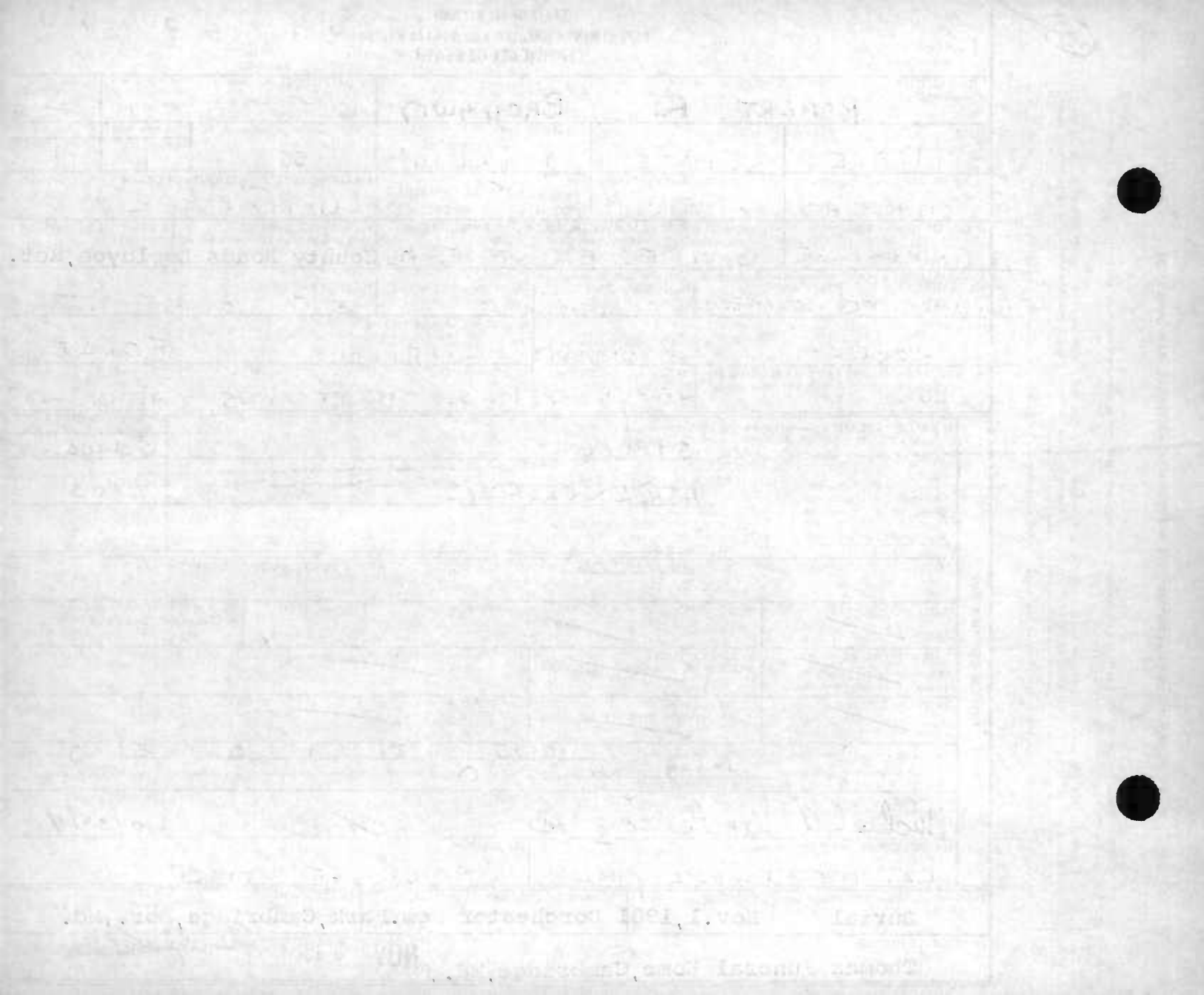
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 6 0 8 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT R. BROHAWN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 30, 1981</b>		2b. HOUR <b>7:30 A</b> M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/11/14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>County Roads Employee, Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>CAMBRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT BROHAWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>STELLA FOXWELL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>217-36-0547</b>		17. INFORMANT ADDRESS <b>HOSPITAL RECORDS (CAMBRIDGE)</b>				18. CAUSE OF DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>10/29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>10/29</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>81</b> , to <b>10/30</b> , 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>10/29</b> , 19 <b>81</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Michael A. Noskiewicz MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/30/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NOSKIEWICZ, MD</b>		22e. ADDRESS <b>CAMBRIDGE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 1, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dor. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home, Cambridge, Md.</b>		ADDRESS <b>CAMBRIDGE, MD</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 3 1981</b>			



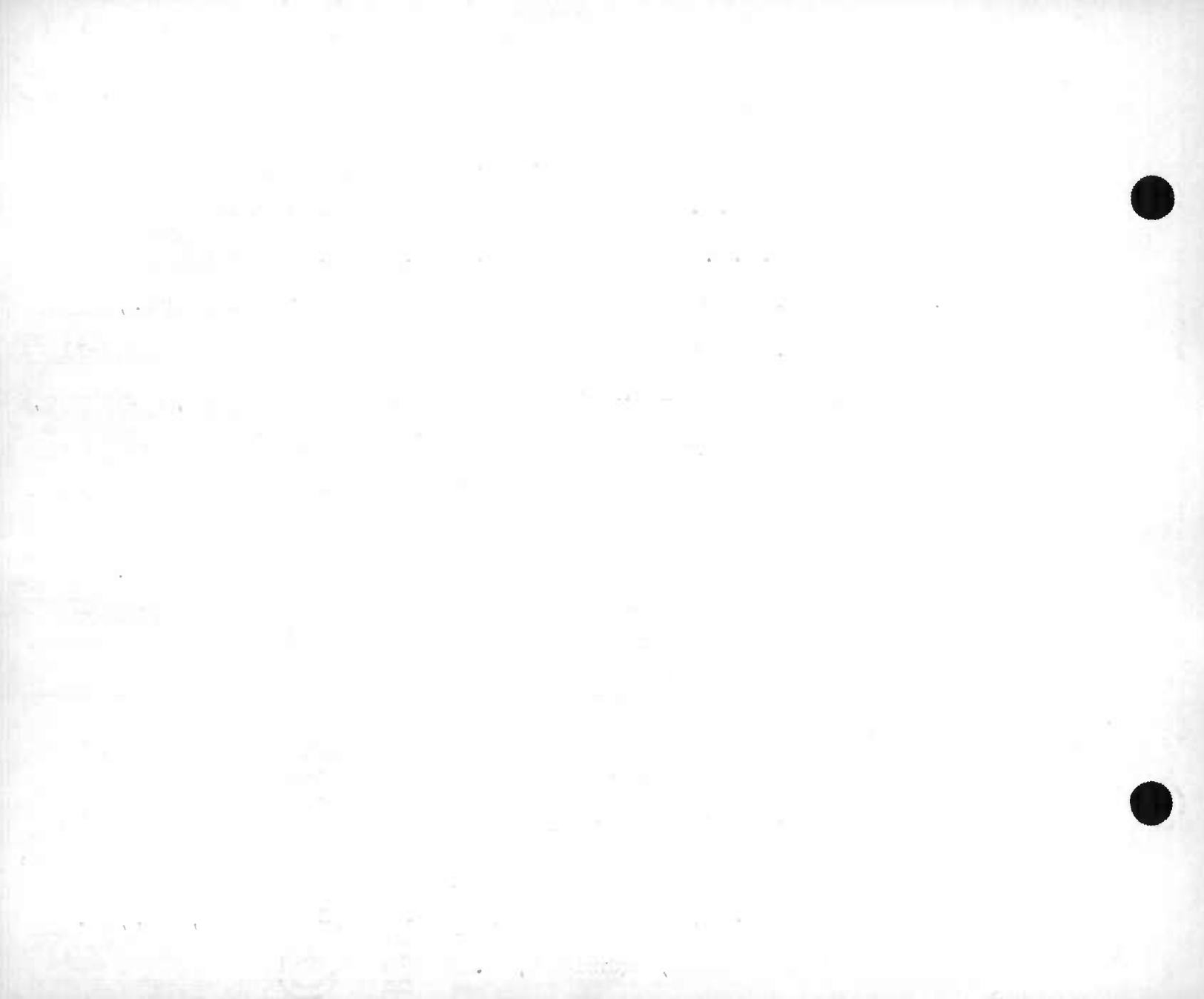


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM A BROTEMARKLE				2a. DATE OF DEATH MONTH DAY YEAR 10 11 81			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 15, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D.O.A. Dorchester Genl. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Educator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Brotemarkle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kendall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT ADDRESS Mattie Brown Brotemarkle, Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 60 min. over 10 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1980 to OCT 11, 1981, that (2) (we) last saw the deceased alive on 10/11/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael A. Mosherowicz				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSHEROWICZ MD.				22e. ADDRESS 503 BURN ST CAMBRIDGE Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 14, 1981		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park, Cambridge, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR OCT 14 1981		25b. REGISTRAR'S SIGNATURE Frances Van Natten	





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Jess Middle H. Last Cornor			2a. DATE OF DEATH Month October Day 5 Year 1981			2b. HOUR 1:40 A M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 11-6-88		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dorchester General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY Montgomery		13c. CITY OR TOWN Brookeville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4415 Brookeville Rd.		
14. FATHER'S NAME First George Middle Last Cornor			15. MOTHER'S MAIDEN NAME First Sarah Middle Last Cassell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN No			16b. SOCIAL SECURITY NO. 215-20-2704		17. INFORMANT Address Barbara McClosky, Item 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>With metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized Arteriosclerosis?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1981</u> , to <u>10/5/81</u> , that (I) (we) last saw the deceased alive on <u>10/5/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lawrence Maryann M.D.</u>			22c. DATE SIGNED <u>10/5/81</u>			22d. PHYSICIAN'S NAME (Type) <u>Lawrence Maryann</u>			22e. ADDRESS <u>Cambridge, Md 21613</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Oct. 7, 1981</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>			23d. LOCATION (City or Town) (County) (State) <u>Goshen, Montgomery, Md.</u>		
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, P.A.,</u>			ADDRESS <u>Damascus, Md.</u>			25a. RECEIVED BY REGISTRAR <u>OCT 8 1981</u>			25b. REGISTRAR'S SIGNATURE <u>Charles J. Nathan</u>		

Here:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 1 2 6 6 8 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lena Irene Deckert</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>10 20 81</u> 2b. HOUR <u>5<sup>20</sup> A</u> M				
3. SEX <u>FEMALE</u>		4. RACE <u>CAU.</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>APRIL 6, 1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD			
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Cambridge House Nursing Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <u>864 W. Lombard St.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>JOSEPH RAYMOND WARFIELD</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>EMMA WOOTEN</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO <u>212-07-5386</u>		17. INFORMANT (brother) ADDRESS <u>Maryland 21613 Ernest Warfield, Rt. 3, Box 319, Cambridge,</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Heart Failure</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease</u> 5 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/81</u> 19 to <u>10/20/81</u> 19, that (I) (we) last saw the deceased alive on <u>10/19/81</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lawrence Marganov, MD</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/20/81</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence Marganov, MD</u>					22e. ADDRESS <u>Cambridge, Md 21613</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>Oct. 22, 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Pk</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Airey, Cambridge, Dorchester, Md.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Curran Funeral Home, 308 High St., Cambridge, Md. 21613</u>					25a. DATE REC'D. BY REGISTRAR <u>OCT 23 1981</u>		25b. REGISTRAR'S SIGNATURE <u>James W. Northen</u>		



*[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

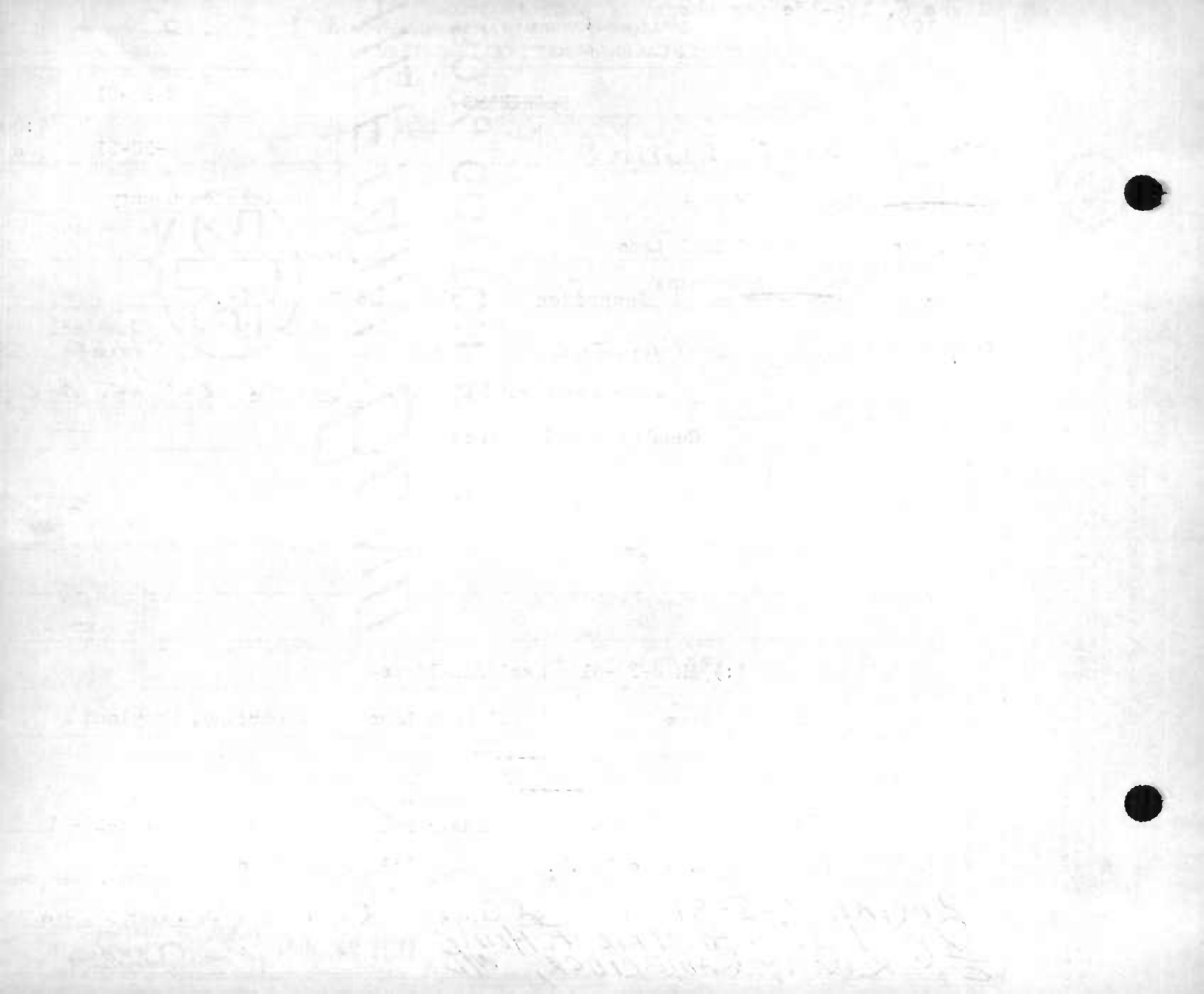
OCT 28 1941

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.			
Items 6 13a-13e per phone FOR 10/30/81 dad 1- STATE REGISTRAR Item #1817, 14&15 Film G564 2/19/82 IC										2 6 0 8 4			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEONARD DASHIELL</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>8-30-81</b>		2b. HOUR M <b>2:00</b>					
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 30 1950</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>31 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8-30-81</b>		2d. HOUR M <b>am</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>							
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>861 Park Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>857 Park Ln.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Chester</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luth Elizabeth Dashiell Chase</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>217-54-5490</b>			17. INFORMANT ADDRESS <b>Vivian Dashiell 861 Park Lane</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Gunshot wound of chest</b> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1:00AM 8-30-81</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:00AM 8-30-81</b>								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self/inflicted</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>861 Park Lane Cambridge, Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Margie DeKelle</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>8-31-81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>9-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Lane</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dorchester Md.</b>					
24. FUNERAL DIRECTOR <b>J. C. Delane</b>				DATE REC'D. BY REGISTRAR <b>OCT 26 1981</b>				25. REGISTRAR'S SIGNATURE <b>James J. North</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 2 6 6 8 5					
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL I HILL					20. DATE OF DEATH MONTH DAY YEAR 2b HOUR 10 19 81 3:20 AM					
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 11 30 14		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 66		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.				
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING		
13a. STATE Md					13b. COUNTY COC		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SAMUEL HUBBARD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE Seward					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-0831D		17. INFORMANT ADDRESS SADIE RHEA 228-5089			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 96 hr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 10/18/81 to 10/19/81, that (1) we last saw the deceased alive on 10/18/81, and that in my (1) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)										
22b. SIGNATURE H.L. FIERY					DEGREE			22c. DATE SIGNED 10/19/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.L. FIERY					22e. ADDRESS 503 BYRN STREET CAMB. Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-21-1981		23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward		23d. LOCATION CITY OR TOWN COUNTY STATE Hudson, Dorchester Md.			
24. FUNERAL DIRECTOR NAME Curran Funeral Home					ADDRESS 308 High St. Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR OCT 20 1981			
					25b. REGISTRAR'S SIGNATURE Francis VanNathan					





CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>PATRICIA</b> First <b>H.</b> Middle <b>HOPKINS</b> Last			2a. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>81</b>			2b. HOUR <b>3:50</b> AM					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 17, 1931</b>		6. AGE (In years last birthday) <b>50</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dorchester General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>306 Collins Avenue</b>		
14. FATHER'S NAME First <b>Ernest</b> Middle <b>M.</b> Last <b>Horton, Sr.</b>			15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>Suber</b> Last <b>Suber</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>249-40-1830</b>		17. INFORMANT <b>William R. Hopkins Hurlock, MD 21643</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASTROCYTOMA GRADE IV</b> <b>1919</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>10/20/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASTROCYTOMA</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>1919</b>			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>1919</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>1919</b>			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (1) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>81</b> , to <b>10/20</b> , 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>10/19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Michael A. Moskiewicz MD</b>			22c. DATE SIGNED <b>10/20/81</b>			22d. PHYSICIAN'S NAME (Type) <b>MICHAEL A. MOSKIEWICZ</b>					
22e. ADDRESS <b>503 BYRN ST CAMBRIDGE</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-23-81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Dorchester, MD</b>		
24. FUNERAL DIRECTOR <b>Zeller Funeral Home, East New Marker, MD</b>			25a. REC'D BY REGISTRAR <b>NOV 2 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no later than 72 hours after death.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 6 8 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Meta Marie Hummer			2a. DATE OF DEATH MONTH DAY YEAR October 24 1981		2b. HOUR 0800 <sup>M</sup>
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02 10 1928	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH E. New Market	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Main St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Airpax Electronics		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Dor.	13c. CITY OR TOWN E. New Market	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Main St.	
14. FATHER'S NAME FIRST MIDDLE LAST William Leslie Hurley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Hurley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-22-9604		17. INFORMANT ADDRESS Wilmer S. Hummer Box 1 E. New Market	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METABOLIC IMBALANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WIDESPREAD SQUAMOUS CELL CARCINOMA LEFT</u> <u>1629</u> <u>1-2 WKS</u> <u>9+ MONTHS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>TERMINAL</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 17</u> 19 <u>78</u> to <u>Oct 24</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Oct 24</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donald R. McWilliams</u>		DEGREE M.D.		22c. DATE SIGNED <u>OCT 26/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.		22e. ADDRESS <u>308 GAY STREET</u> <u>CAMBRIDGE, MD. 21613</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/27/81		23c. NAME OF CEMETERY OR CREMATORY E. New Market Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE E. New Market Dor. Md.		23e. DATE REC'D. BY REGISTRAR OCT 30 1981			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home		25a. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 6 0 8 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>CHARLES J. JOLLEY</u>				2a. DATE OF DEATH		2b. HOUR	
3 SEX <u>Male</u>				4 RACE <u>Negro</u>		5 DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS.	
10. CITY OR TOWN OF DEATH <u>Cambridge</u>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hosp.</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laborer</u>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Md.</u>				13b. CITY OR TOWN <u>Dorchester</u>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <u>Charles G. Jolley</u>				15. MOTHER'S MAIDEN NAME <u>Rosie Etta Ward</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Emma Cornish Taylors Is., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burichogenic CA 8gmous cell of</u>							
1625- <u>left lower lobe with metastasis to liver</u>							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-13-81</u> to <u>10-23-81</u> , that (I) (we) lost <u>10-23-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>J. Edwin Fossett</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>10/23/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Edwin Fossett</u>				22e. ADDRESS <u>P.O. Box 516 Cambridge Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>10-29-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Mem. Cem.</u>	
23d. LOCATION CITY OR TOWN <u>Smithville</u> COUNTY <u>Dor.</u> STATE <u>Md.</u>							
24. FUNERAL DIRECTOR NAME <u>L.H. Boardley</u> ADDRESS <u>F/H Camb., Md. 21613</u>				25. DATE REC'D. BY REGISTRAR <u>OCT 30 1981</u>			
				26. REGISTRAR'S SIGNATURE <u>James J. Van Natta</u>			

Y=3.11

52

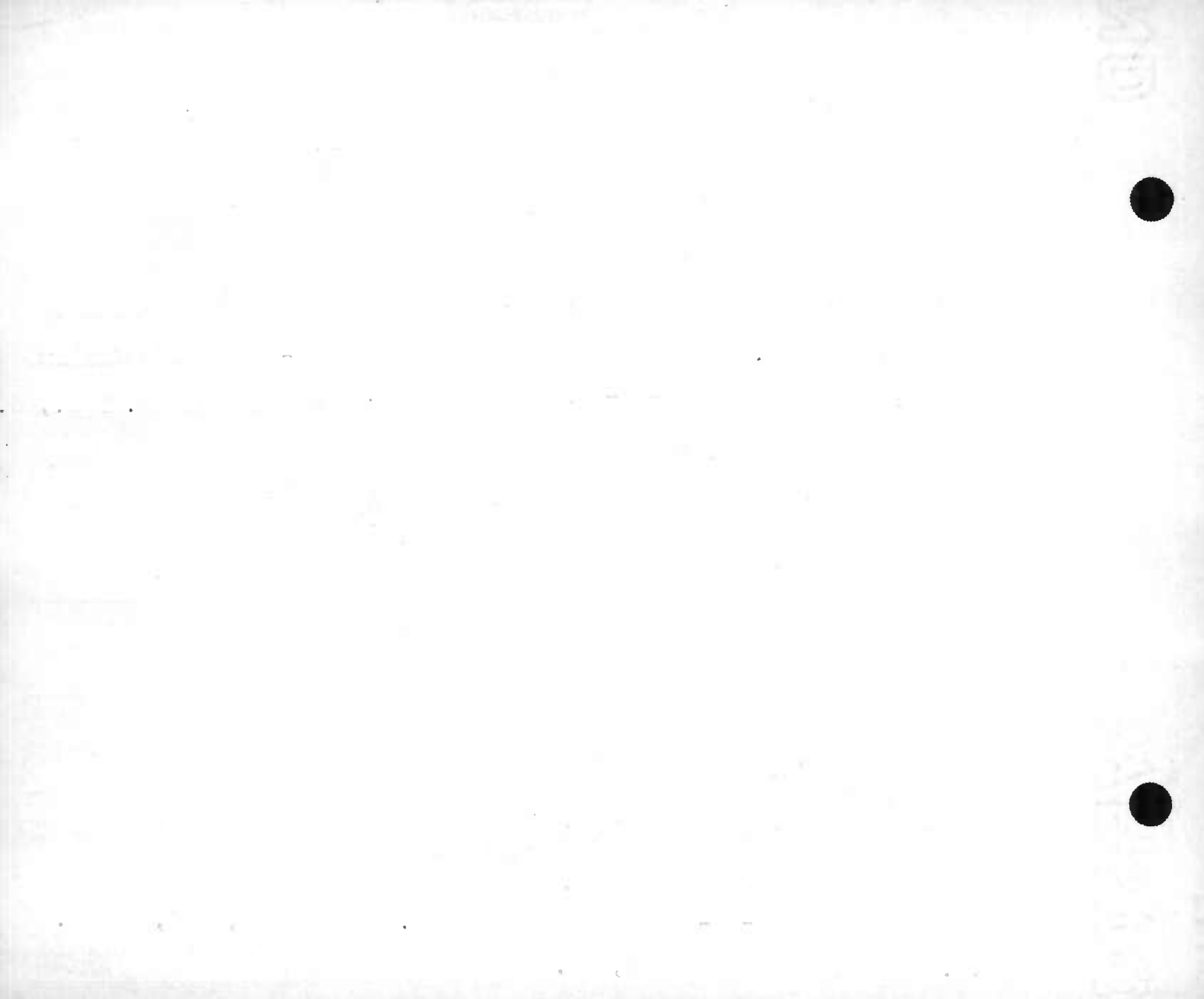


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 8 1 2 6 6 8 9							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST MIDDLE LAST Violet M. Kane			MONTH DAY YEAR October 12 1981			12 59 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		Black		MONTH DAY YEAR 11 16 09		71 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.				Dorchester MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge		Dorchester General Hospital				Retired				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
13a. State			13b. County			13c. City or Town			13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Dorchester			Cambridge			701 Race St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William B. Cooper			FIRST MIDDLE LAST Mabel - Rittinham							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
No			216-14-9666			Anniebell Cooper 701 Race St. Camb., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Aspiration of vomitus										
4100 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Probable myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Generalized arteriosclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
Diabetes										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from October 12, 1981, to Oct 12, 1981, that (we) last saw the deceased alive on October 11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Frank R. Claudy MD								October 12, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
CLAUDY, FRANK R			Dept. Family Practice, U. of Md Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			10-16-81		Bethel Cem.		Cambridge, Dor, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
L.H. Boardley F/H Cambridge, Md.						OCT 16 1981		James Jean Nathan		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 6 9 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Willie Allen Keene</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 25 1981</b>		2b. HOUR <b>9:30 PM</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 23 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>en route to Dor. General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ulys Harry Keene</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie C. Todd</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-07-9206</b>		17. INFORMANT ADDRESS <b>Mrs. Lena Keene Item #13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**C.H.F. Class IV NYHA.**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5920  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Nephrolithiasis.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>— Cambridge Dor. Md.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 26, 1981</b> , to <b>Sept 24, 1981</b> , that (I) (we) last saw the deceased alive on <b>Sept 24, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas</b>		DEGREE <b>—</b>		22c. DATE SIGNED <b>10/28/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>10/28/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>
24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home</b>		ADDRESS <b>PO Box 348 Camb. Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1981</b>
		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Keene</b>	

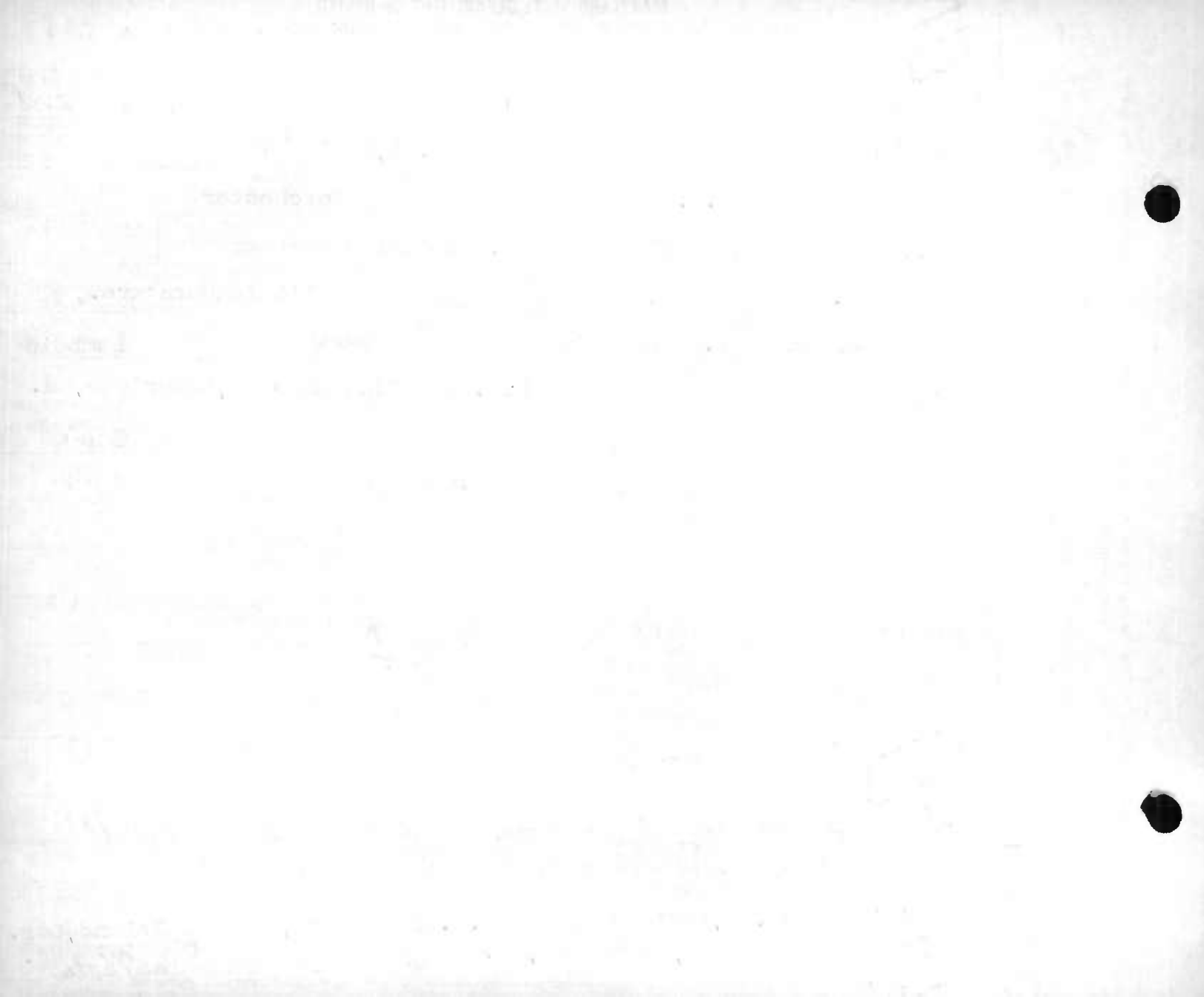


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6 6 9 1  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>VIRGINIA R. LAMBDIN</b>			2a. DATE OF DEATH Month Day Year <b>10 11 81</b>			2b. HOUR <b>2:30 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 11, 1911</b>		6. AGE (In years birthday) YRS. <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dorchester Genl. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>311 Glenburn Ave.,</b>	
14. FATHER'S NAME First Middle Last <b>Robert T. Lambdin</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Lambdin</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Madeline Shenton, Cambridge, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PERFORATED COLON</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADENOCARCINOMA OF COLON</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WK</b> <b>2 WK</b> <b>?</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <b>10/6/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ACUTE ABDOMEN</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>CAUSE OF DEATH</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec, 1980</b> , to <b>Oct 11, 1981</b> , that (I) (we) last saw the deceased alive on <b>Oct 11, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael A. Moskewicz</b>				22c. DATE SIGNED <b>10/11/81</b>		22d. PHYSICIAN'S NAME (Type) <b>MICHAEL A. MOSKEWICZ</b>			
22e. ADDRESS <b>503 BURN ST.</b>									
23a. BURIAL, CREMATION, REBURY <b>Burial</b>		23b. DATE <b>Oct. 13, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethlehem U.M. Churchyard, Taylors Island, Dor.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Thomas Funeral Home, Cambridge, Md.</b>				25. REC'D BY REGISTRAR <b>OCT 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Betty W. Meekins					2a. DATE OF DEATH MONTH DAY YEAR October 14, 1981					2b. HOUR 5:15pm
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec 13 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Centreville		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assoc. Realtor		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS rural		
14. FATHER'S NAME FIRST MIDDLE LAST S. Charles Walls Jr					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Durney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-07-7884		17. INFORMANT ADDRESS G. Tinsley Meekins PO Box 83 Linkwood Md. 21835			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sev. 9-2</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Charles Walls Jr</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR M.S. SHARIFE					22e. ADDRESS 105 AURORA ST. CAMBRIDGE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 10/16/81		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dorchester MD			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home					ADDRESS Cambridge Md.		25a. DATE REC'D. BY REGISTRAR OCT 21 1981			



RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

DATE: DECEMBER 1, 1961  
TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-157111)  
SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, NOVEMBER 29, 1961.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON NOVEMBER 29, 1961, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM AN INDIVIDUAL WHO IDENTIFIED HIMSELF AS JAMES EARL RAY.

THE INDIVIDUAL STATED THAT HE WAS CURRENTLY IN NEW YORK CITY AND WANTED TO SPEAK TO THE DIRECTOR OF THE FBI.

THE NEW YORK OFFICE ATTEMPTED TO LOCATE THE INDIVIDUAL BUT WAS UNABLE TO DO SO.

THE NEW YORK OFFICE IS CURRENTLY ATTEMPTING TO LOCATE THE INDIVIDUAL AND WILL REPORT THE RESULTS OF ITS SEARCH TO THE BUREAU.

THE NEW YORK OFFICE IS ALSO ATTEMPTING TO LOCATE THE INDIVIDUAL'S CURRENT RESIDENCE AND WILL REPORT THE RESULTS OF ITS SEARCH TO THE BUREAU.

THE NEW YORK OFFICE IS CURRENTLY ATTEMPTING TO LOCATE THE INDIVIDUAL AND WILL REPORT THE RESULTS OF ITS SEARCH TO THE BUREAU.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 26693			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Monroe Milbourne</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10-1-81</b>			
2b. HOUR <b>12:30 AM</b>							
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 15-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Eastern Shore Hosp Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Deal Island</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST <b>Lerin Milbourne</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret LONG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-05-6400</b>		17. INFORMANT <b>Records - ESHC - Camb.</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1991 <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardio</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO, OR AS A CONSEQUENCE OF - Vascular Disease</b>							
DUE TO, OR AS A CONSEQUENCE OF <b>Generalized Arteriosclerosis</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-4-81</b> 19 <b>10-1-81</b> , to <b>10-1-81</b> , that (I) (we) last saw the deceased alive on <b>10-1-81</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Evangelina M. Garcia</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-1-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EVANGELINE GARCIA</b>				22e. ADDRESS <b>ESHC, Cambridge, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS)		23b. DATE <b>OCT 6-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Deal Island Somerset Md.</b>	
24. FUNERAL DIRECTOR NAME <b>LEROY WEBSTER</b>		ADDRESS <b>Rt 3 - Princess Anne Md 21853</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Jan Warren</b>	

24

12-20-81  
To: [illegible]  
From: [illegible]  
Subject: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter. It contains several paragraphs of text, some of which may be related to land management or a specific project. Key words like "Bureau of Land Management" and "Washington, D.C." are visible in the header area.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 2 6 6 9 4	
1 - STATE REGISTRAR					CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH	
Lounie Moody					10 25 81 8:15 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		
MALE		NEGRO		1 3 18		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		
SOUTH CAROLINA		USA		63 YRS		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH		
CAMBRIDGE		DORCHESTER GENERAL		DORCHESTER MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Construction						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		
MARYLAND		DORCHESTER		CAMBRIDGE		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		
JOHN		MOODY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
UNKNOWN		243-16-1180		Wilbert Moody		
18. IMMEDIATE CAUSE (a)		18b. SOCIAL SECURITY NO.		17. ADDRESS		
1850		243-16-1180		Wash., D. C.		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19b. SOCIAL SECURITY NO.		17. ADDRESS		
Myocardial Infarction		243-16-1180		Wash., D. C.		
DUE TO, OR AS A CONSEQUENCE OF		19c. SOCIAL SECURITY NO.		17. ADDRESS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		243-16-1180		Wash., D. C.		
(b) Carcinoma of prostate with metastases		243-16-1180		Wash., D. C.		
(c) Chronic Heart Failure		243-16-1180		Wash., D. C.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		243-16-1180		Wash., D. C.		
Coronary Insufficiency - Anemia		243-16-1180		Wash., D. C.		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
		P.M. 19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/25/81 19, to 10/25/81 19, that (I) (we) lost saw the deceased alive on 10/25/81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		
		Lawrence Maryanov MD		10/25/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Lawrence Maryanov		Cambridge, Md 21613				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		
Removal		10/30/81				
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR		
Anatomy Board		11/6/81		Thom...		

Nooby

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Willard Nooby

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the funeral director. Pages 5 and 6 should be filed with the funeral director. Pages 7 and 8 should be filed with the funeral director. Pages 9 and 10 should be filed with the funeral director. Pages 11 and 12 should be filed with the funeral director. Pages 13 and 14 should be filed with the funeral director. Pages 15 and 16 should be filed with the funeral director. Pages 17 and 18 should be filed with the funeral director. Pages 19 and 20 should be filed with the funeral director. Pages 21 and 22 should be filed with the funeral director. Pages 23 and 24 should be filed with the funeral director. Pages 25 and 26 should be filed with the funeral director. Pages 27 and 28 should be filed with the funeral director. Pages 29 and 30 should be filed with the funeral director. Pages 31 and 32 should be filed with the funeral director. Pages 33 and 34 should be filed with the funeral director. Pages 35 and 36 should be filed with the funeral director. Pages 37 and 38 should be filed with the funeral director. Pages 39 and 40 should be filed with the funeral director. Pages 41 and 42 should be filed with the funeral director. Pages 43 and 44 should be filed with the funeral director. Pages 45 and 46 should be filed with the funeral director. Pages 47 and 48 should be filed with the funeral director. Pages 49 and 50 should be filed with the funeral director. Pages 51 and 52 should be filed with the funeral director. Pages 53 and 54 should be filed with the funeral director. Pages 55 and 56 should be filed with the funeral director. Pages 57 and 58 should be filed with the funeral director. Pages 59 and 60 should be filed with the funeral director. Pages 61 and 62 should be filed with the funeral director. Pages 63 and 64 should be filed with the funeral director. Pages 65 and 66 should be filed with the funeral director. Pages 67 and 68 should be filed with the funeral director. Pages 69 and 70 should be filed with the funeral director. Pages 71 and 72 should be filed with the funeral director. Pages 73 and 74 should be filed with the funeral director. Pages 75 and 76 should be filed with the funeral director. Pages 77 and 78 should be filed with the funeral director. Pages 79 and 80 should be filed with the funeral director. Pages 81 and 82 should be filed with the funeral director. Pages 83 and 84 should be filed with the funeral director. Pages 85 and 86 should be filed with the funeral director. Pages 87 and 88 should be filed with the funeral director. Pages 89 and 90 should be filed with the funeral director. Pages 91 and 92 should be filed with the funeral director. Pages 93 and 94 should be filed with the funeral director. Pages 95 and 96 should be filed with the funeral director. Pages 97 and 98 should be filed with the funeral director. Pages 99 and 100 should be filed with the funeral director.

BP

DDH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>ANNA B Paul</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>10-14-81</i>			2b. HOUR <i>9:10 A</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 15, 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		9. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.				
12. CITY OR TOWN OF DEATH <i>Cambridge</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester Genl. Hospital</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		15. KIND OF BUSINESS OR INDUSTRY		
16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>			13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>504 W. Appleby Ave.,</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas W. Inslay</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virgie Abbott</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>214-07-8628</i>		17. INFORMANT ADDRESS <i>Randolph Paul, Cambridge, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>5609</i> IMMEDIATE CAUSE (a) <i>lack bowel obstruction</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>obstruction</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>obstruction</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Severe chronic pulmonary disease</i>										
19a. DATE OF OPERATION <i>N/A</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>N/A</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>N/A</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) <i>N/A</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>N/A</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/14/81</i> to <i>10/14/81</i> , that (I) (we) lost saw the deceased alive on <i>10/14/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Arwin</i>			DEGREE			22c. DATE SIGNED <i>10/14/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arwin</i>			22e. ADDRESS <i>400 Maryland Ave Cambridge 2161</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>Oct. 16, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cambridge, Dor., Md.</i>			
24. FUNERAL DIRECTOR <i>Thomas Funeral Home, Cambridge, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>OCT 19 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James Van Notten</i>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for price.

MEDICAL CERTIFICATION

10:10

October

October 10, 1941

Dear Sir,

I am writing to you regarding the

matter of the

last part of the

document

which is now being

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10

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10

Yours very truly,

ABC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST		10-11-81			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		Negro		05-15-09		72		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
VIRGINIA		USA				Dorchester County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital		LABORER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		620 Douglas Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST		LAST		FIRST		MIDDLE		LAST	
UNKNOWN		UNKNOWN		NO				HELEN J. SCOTT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4291		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cardiac Arrest				Atrial fibrillation and Multiple					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) premature Ventricular Contractions					
				DUE TO, OR AS A CONSEQUENCE OF					
				Degenerative Heart Disease, ..					
				(c) occlusion					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Right sided pleural									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-12-1979, to 10-11-1981, that (I) (we) last saw the deceased alive on 10-11-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
J. Edwin Fassett M.D.		MD				10-11-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
J. Edwin Fassett M.D.		806 Fairmount Ave. Cambridge. Md.							
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		10-17-81		BETHEL		CAMBRIDGE		DOR. MD.	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
J. Edwin Fassett		31 CLARE F. HOME		OCT 26 1981		James J. Harte			
		CAMBRIDGE, MD							

1999

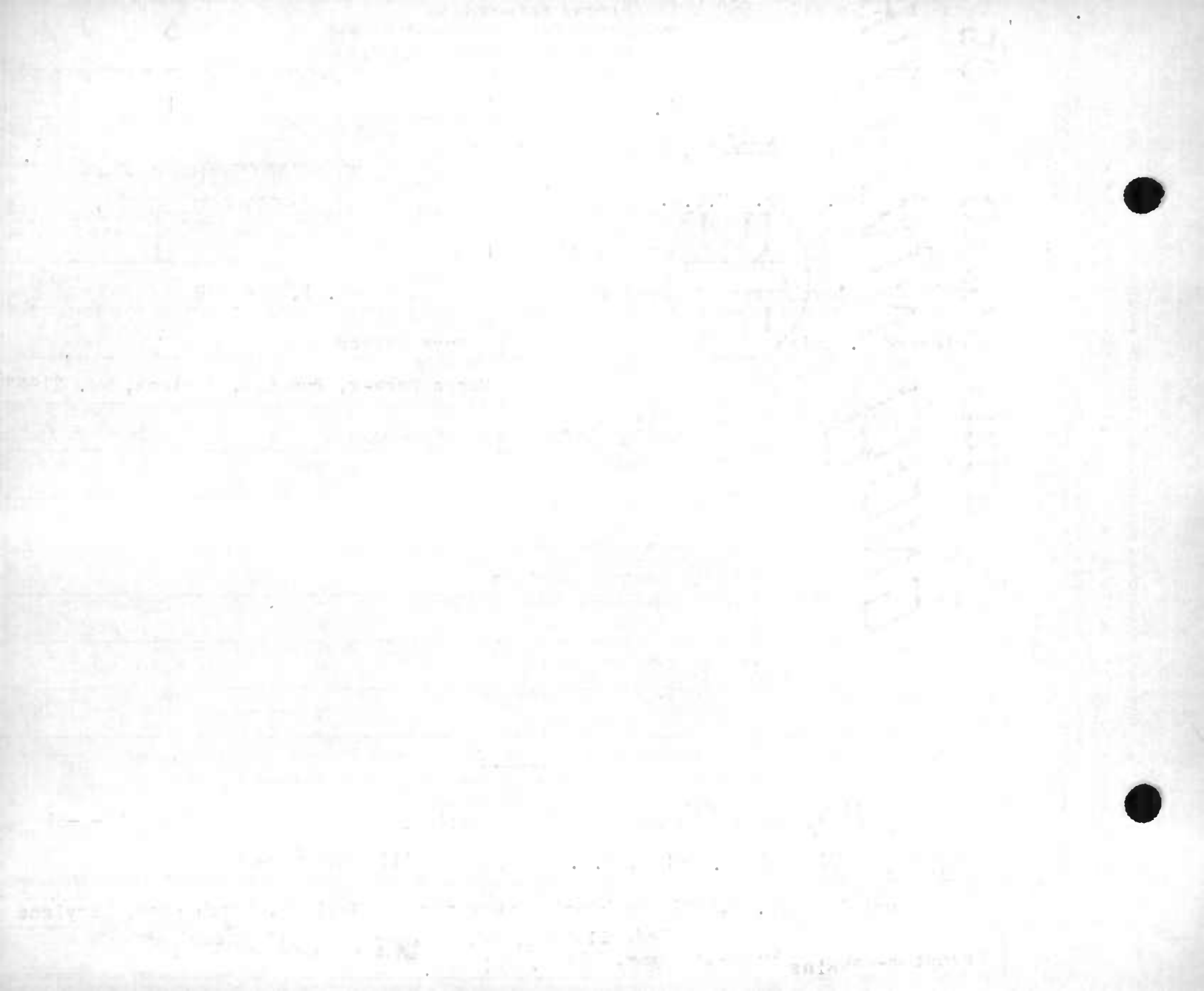
Items #182-22a Film G560 10/29/81 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26097

1. DECEASED NAME (TYPE OR PRINT) Richard L. Smith		2a. DATE KNOWN OF DEATH 10 2 19 81		2b. HOUR M
1. SEX Male	4. RACE Black	5. DATE OF BIRTH June 30, 1981	6. AGE (IN YEARS) 3 YRS. 2 MONTHS	7c. DATE PRONOUNCED DEAD 10 2 19 81
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester Gen. Hosp.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County, MD.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. CITY OR TOWN Hurlock	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS Rt. 1, Box 609	
14. FATHER'S NAME Richard A. Smith		15. MOTHER'S MAIDEN NAME Vonya Parker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS Vonya Parker, Box 609, Hurlock, Md. 21643		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). (Viral) Gastroenteritis				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Virginia L. Dolan		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 10-3-81
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 5, 1981	23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester, Maryland	
24. FUNERAL DIRECTOR NAME Frampton-Hawkins		ADDRESS Federalburg, Md. 216 N. Main St.		25. DATE RECD. BY REGISTRAR OCT 7 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

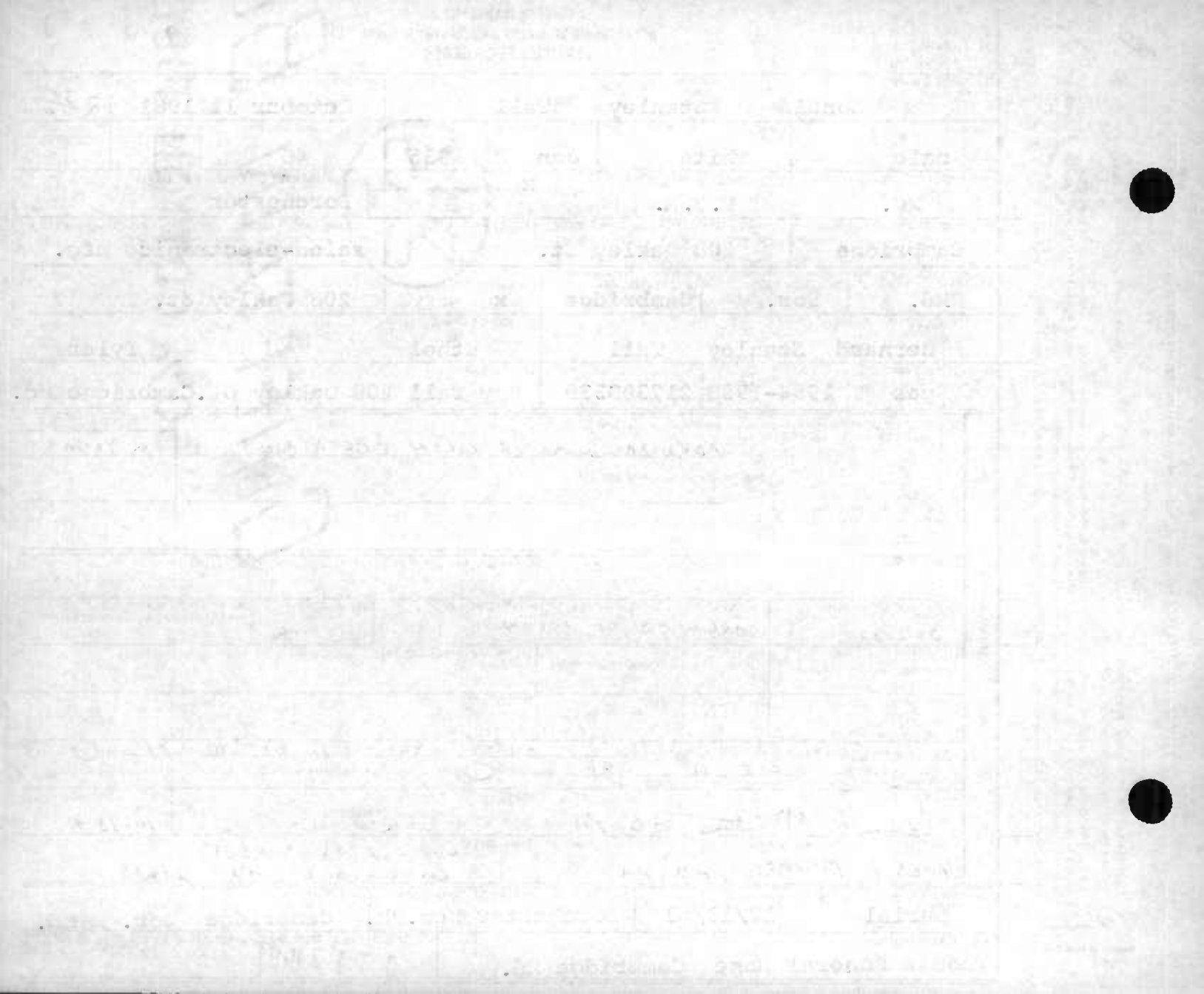


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 6 5 9 8			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Donald Stanley Tall				October 11 1981			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		white		Jan 8 1935		46 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.				Dorchester MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		208 Oakley St.		sales-electronics		mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Bernard Stanley Tall				Ethel Tyler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes				1954-1958		217308339 Kay Tall 208 Oakley St. Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF COLON &amp; METASTASES</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
3-12-80		CARCINOMA OF COLON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital) attended the deceased from <u>MARCH</u> , 19 <u>80</u> , to <u>OCT 11</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>OCT 11</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>James F. McEwen, M.D., P.A.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-13-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JAMES F. MCEWEN, M.D., P.A.		400 AURORA STREET CAMBRIDGE, MD. 21613					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/13/81		Dorchester Mem.Pk.		Cambridge Dor. MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
Thomas Funeral Home Cambridge Md.				OCT 19 1981			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

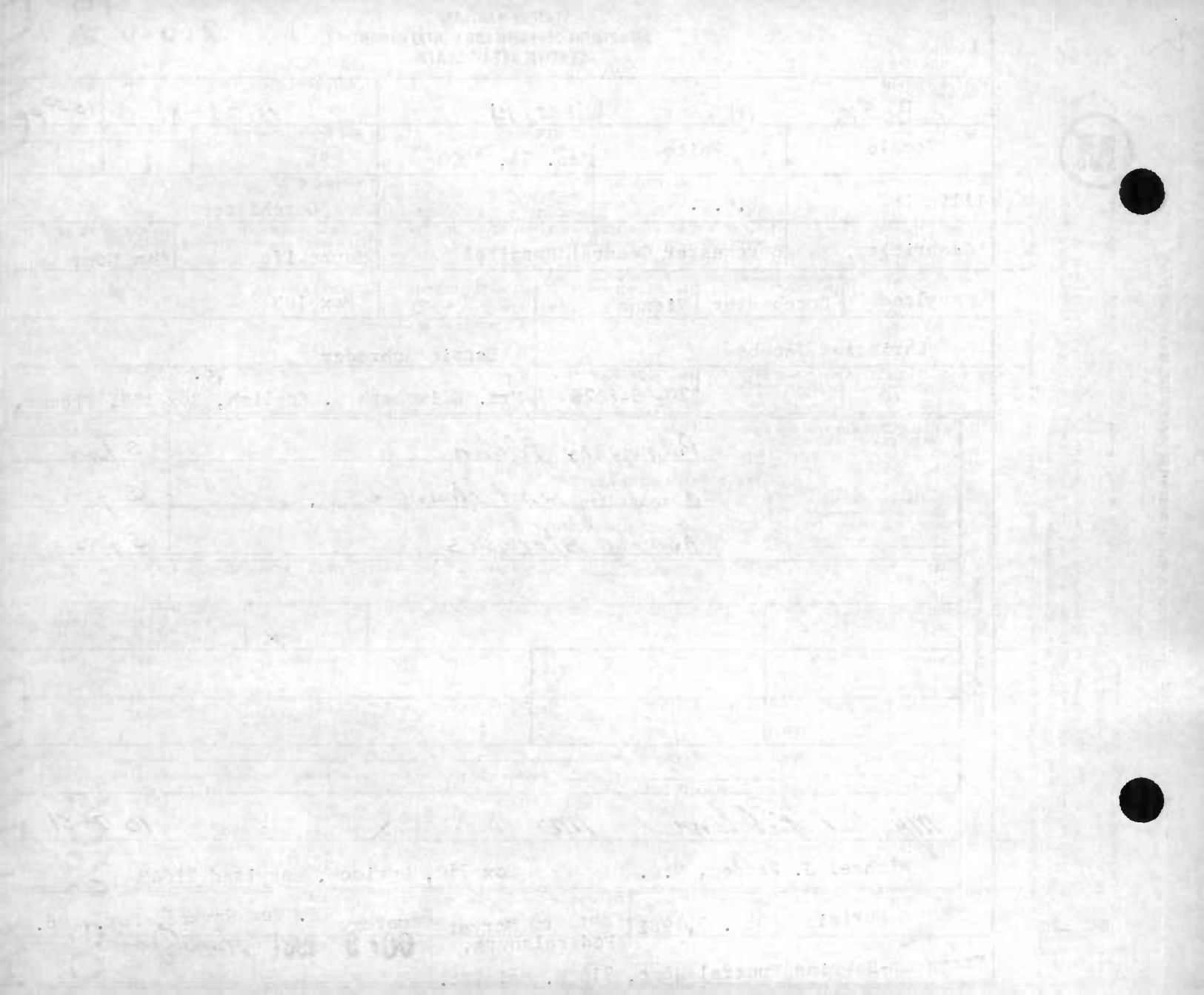
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 6 6 9 9	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Bessie M Wheatley</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10-1-81</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 24, 1900</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Vienna</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christian Jacobs</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Schroder</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>220-09-8628</b>		17. INFORMANT <b>Mrs. Elizabeth K. English, Box 103, Vienna,</b>		18. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aortic Stenosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>5 yrs</b> <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael Fadden</b> MD		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-7-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael J. Fadden, M.D.</b>		22e. ADDRESS <b>Box 750, Hurlock, Maryland 21643</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 5, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. New Market Dor. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Frampton-Hawkins Funeral Home, 216 N. Main St.</b>			
25. FILE RECD. BY REGISTRAR		25b. DATE <b>Oct 9 1981</b>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
1VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26700

1. DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE R.		LAST Whittington		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 10		DAY 25		YEAR 1981		2b. HOUR AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9- 8- 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/25/ 1981		2d. HOUR AM		2e. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/25/ 1981		2f. HOUR AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.											
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1022 Pine St.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1022 Pine St.									
14. FATHER'S NAME FIRST MIDDLE LAST Bruce Whittington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula ?															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-8585		17. INFORMANT ADDRESS Mrs. Iona Whittington (13a.)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few mins.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER										DATE SIGNED 10/26/81			
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.		ADDRESS Cambridge, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/81		23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem.		23d. LOCATION CITY OR TOWN Cambridge, Dor.		STATE Md.									
24. FUNERAL DIRECTOR NAME Boardley Funeral Home		ADDRESS Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR OCT 30 1981		25b. REGISTRAR'S SIGNATURE <i>Charles J. Van Winkle</i>											

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALICE HIGGINS WILLEY			2a. DATE OF DEATH MONTH DAY YEAR 10 28 81		2b. HOUR 10 55 AM							
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 58 yrs. YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Camb., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly worker		12b. KIND OF BUSINESS OR INDUSTRY electronic				
13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Viennad		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D. 1, Box 72, Vienna, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Phillip J. Higgins, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Catherine Davis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-3353		17. INFORMANT daughter			ADDRESS 21613 Sheree Willey, Route 4, Box 202, Cambridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												
19a. DATE OF OPERATION _____			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____		CITY OR TOWN _____		COUNTY _____		STATE _____	
22a. I certify that (1) (this hospital) attended the deceased from <u>10/20/81</u> to <u>10/28/81</u> , that (1) (we) last saw the deceased alive on <u>10/20/81</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Michael A. Moskewicz MD</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/30/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD						22e. ADDRESS 503 BARN ST						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Oct. 20, 1981		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park.		23d. LOCATION CITY OR TOWN Airey, Cambridge		COUNTY Dorchester		STATE Md.	
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR NOV 2 1981		25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u>				

